ATTACHMENT C-1

Governor's Safe and Drug Free Schools and Communities Program

Monthly Expenditure Report and Reimbursement Request - Instructions

NOTE: All programs must complete **monthly** payment requests for reimbursement of the expenses incurred related to the grant services. Copies of the two forms, BH - 4a (PRV-SDFSC) and BH-1 (PRV-SDFSC), follow this page.

I. BH – 4a (PRV-SDFSC): Expense Reimbursement Document

A. Complete the spaces provided for:

1). **Agency/Program** – descriptive name of agency
2). **Month/Year** – indicate last day of month in which services were rendered (e.g. 12/31/04)
3). **Grant/Contract Number** – grant or contract number for which payment is being requested
4). **Mental Health/Substance Abuse** – check appropriate box

B. Complete the columns:

1). **Current Month's Expenses** – indicate the amount of allowable expenses that are being requested in each category
2). **Total of Prior Expenses** Billed – add all total prior requests for this project for the year and indicate the total in the space provided
3). **Total Expenses Billed To Date –** this is the total of columns B and C, and represents the total reimbursed by state administered funds to the project as of the end of the specific reporting month
4). **Approved Budget Total** – Indicate from your most recent approved budget (or budget adjustment) the approved amounts for each of the categories from the funding award

C. Complete Signatures:

1). An original signature from the Agency Director or Business Manager must be affixed at the signature line.
2). The name and title of the person submitting the payment request should be typed or printed in the spaces provided at the lower right hand side of the form below the signature line.
3). The Expense Reimbursement Document must be dated in the space provided to the right of the name/title line for the signatory.

II. BH – 1 (PRV-SDFSC): Agency Total

A. Complete the spaces provided for:

1). **Agency/Program** – descriptive name of agency
2). **Month/Year** – indicate last day of month in which services were rendered (e.g. 12/31/04)
3). **Grant/Contract Number** – grant or contract number for which payment is being requested

B. Complete the columns:

1). **Total Reimbursement Request/Substance Abuse Total Funds (Column C) -** indicate the total amount of allowable expenses that are being requested.

2). **Total Reimbursement Request/NFFS Total (Column D) -** same as column C

C. Signatures:

4). An original signature from the Agency Director or Business Manager must be affixed at the signature line.

5). The name and title of the person submitting the payment request should be typed or printed in the spaces provided at the lower right hand side of the form below the signature line.

6). The Expense Reimbursement Document must be dated in the space provided to the right of the name/title line for the signatory.

III. Expenditure Reports should be sent to:

Faith Mills
Office of Mental Health, Substance Abuse and Addiction Services
Nebraska Health and Human Services
P.O. Box 98925
Lincoln, NE 68509-8925.